RECORDKEEPING REMINDERS

The Dentistry Examining Board reviews dental health care records as a part of screening and/or investigation of a complaint. This provides us exposure to records very different in content, accuracy and style. We highly recommend it include:

1. Written and dated medical history – signed by the patient.
2. Written examination chart with procedure clearly indicated.
3. Consent form signed by the patient is highly recommended.
4. Radiographs.
5. Anesthetic type, amount administered any unusual reactions.
6. All prescriptions ordered.

Other important recommendations:

1. Never use pencil. Black pen or type is best.
2. Print legibly.
3. Sign or initial every entry.
4. Do not use white out. Cross out incorrect entry with one line; make correction, date and initial.
5. Avoid acronyms that are only understood by the author.
6. If any other staff member is writing in the patient's record, the credential holder (dentist or dental hygienist) is still responsible for its accuracy.

Finally, if your records are requested as part of an investigation, do not rewrite or attempt to "improve" them in any way. Falsification, withholding, concealing, and/or destruction of the patient health care record with the intent to obstruct an investigation or prosecution is a violation under 146.83 (4) (a) (b) (c).

Proper recordkeeping should be a consistent well-understood standard for everyone in the office. Its indication of a standard of care is clearly apparent. Its impact on an investigation is tremendous.